Medical Care Advisory Committee

December 20, 2023

Virtual Meeting Processes

To increase engagement, turn on your video

Mute your microphone upon entry, and until you are ready to speak

Use the chat function to introduce yourself: ***Name, Title, Organization*** *(if any)*

If you have comments or questions, please use the '***Raise Hand***' feature and speak clearly

If you are not a member of the MCAC, kindly hold your questions till the end of the meeting or add your questions to the chat!

Agenda Overview

- **Welcome**
- **Introductions of New Members**
- **DHCF and Other Updates**
  - Medicaid Renewal
  - 1115 Waiver Renewal
  - Stabilization Center
- **Discussion Items**
  - Quality Strategy
  - Business Transformation Technical Assistance Report
- **Subcommittees**
- **Strategy Session Planning**

New Members

- New Voting Members
  - Maria Elena Anderson
  - Dr. Dereje Breeden
  - Dr. Manisha Singal
- Re-appointed Voting Members
  - Chioma Oruh
  - Marie Morilus-Black

- Public Ex-Officio Members
  - Mark LeVota – DC Behavioral Health Association
  - Ian Paregol – DC Coalition of Disability Service Providers
  - Veronica Sharpe – DC Health Care Association
  - Justin Palmer – DC Hospital Association
  - Robert Hay – Medical Society of DC
  - Tricia Quinn – DC Primary Care Association
  - Kurt Gallagher – DC Dental Society
  - Darla Bishop – AmeriHealth Caritas DC
  - Maislyn Christie – Amerigroup DC
  - Leslie Lyles Smith – MedStar Family Choice DC
  - Anna Dunn – HSCSN
  - Colleen Martin - UnitedHealthcare Community Plan of DC

Medicaid Renewal

DHCF is Addressing Ex-Parte Household Renewals Process

- DHCF is addressing recent communications where CMS clarified that *ex parte* (passive or automatic) renewals must be done individually and not at the household level
  - Example: A mother and child are each enrolled in Medicaid on the basis of MAGI, as a household of two. DC's MAGI Medicaid threshold is 216% of the federal poverty level (FPL) for parents/caretaker relatives and 319% of the FPL for children (not counting the 5% disregard). Ex parte eligibility must be processed separately for the mother and the child with respect to the separate eligibility levels.
- DHCF has taken action to ensure compliance:
  - **Reinstatements** are live in MMIS for potentially impacted children with **May through July** certification end dates
  - DHCF **paused** disenrollments for potentially impacted children with **August** certification end dates and beyond

DHCF Has a Plan for a Full System Fix for Ex Parte Renewals

Process

- DHCF is working on a comprehensive fix for ex parte renewals, which will initiate all renewals in a way that is fully compliant with federal ex parte requirements

- This comprehensive fix will allow the District to properly determine which beneficiaries need to renew their coverage within a household before it initiates the renewal process
  - The “polling” process, which happens before renewals are due, is where the District determines who will need a non-passive renewal

- Going forward, the District will conduct polling on an individual level:
  - Where there is sufficient information to passively renew the entire family, the District will continue to do so.
  - If all individuals in the household are polled above the relevant individual thresholds, the individuals in the household will continue to receive a non-passive notice.
  - If only part of the household can be renewed passively, then the remaining members should expect a non-passive renewal (further explained on next slide)

DHCF Has a Plan for a Full System Fix for Ex Parte Renewals (continued)

Process (continued)

- When we do not have the information to passively renew the parent(s) but we do have the information to renew children, the system will generate a non-passive renewal for the household members:
  - If renewal received during certification period verifies entire household eligibility – Household continues in Medicaid
  - If renewal is received after the certification period or is not returned – Child continues in Medicaid regardless of financial information submitted during grace period
  - If renewal is received during certification period and verifies ineligibility of entire household – Household is terminated or transitioned to Transitional Medicaid Assistance

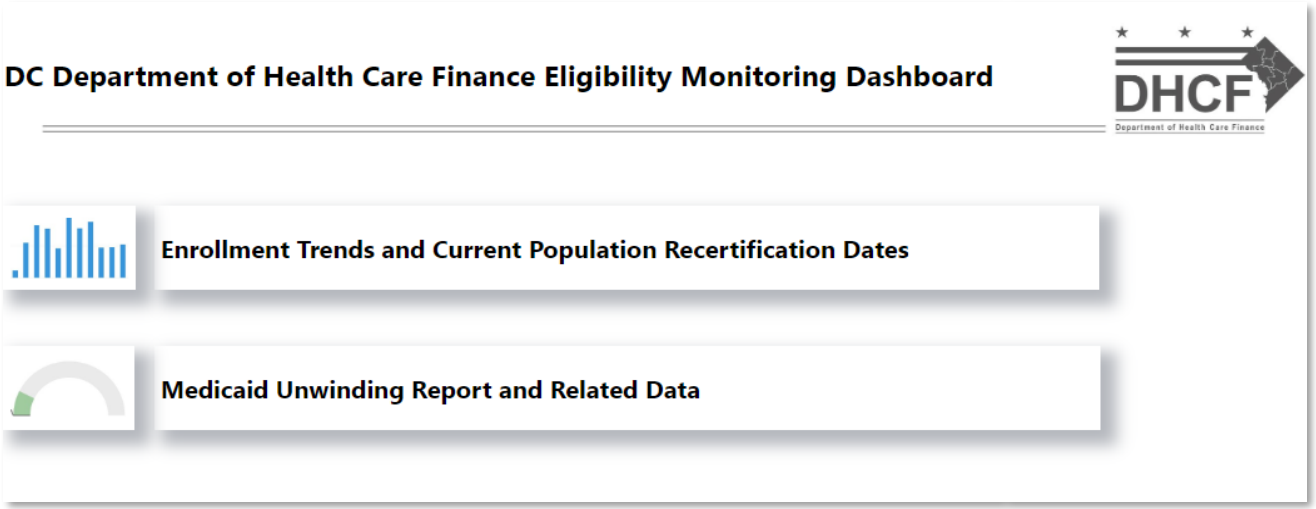
DHCF Has a Timeline for a Full System Fix for Ex Parte Renewals

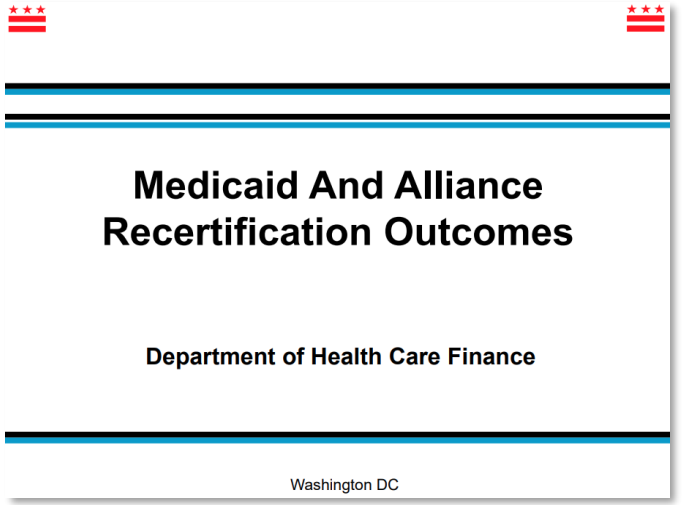
Timeline

- In late December, the District will repoll the affected children who were **reinstated** or **paused**
    - Affected children that poll above the relevant MAGI thresholds will receive a notice of pending adverse action late December/early January (scheduled to take effect February 1)
    - Impacted children that poll below the relevant MAGI thresholds will receive a notice of continued eligibility
- All ex parte polling initiated after December will incorporate the updated system fix.

DC Medicaid Renewal Data Is Publicly Available and Regularly Updated on the DHCF Website

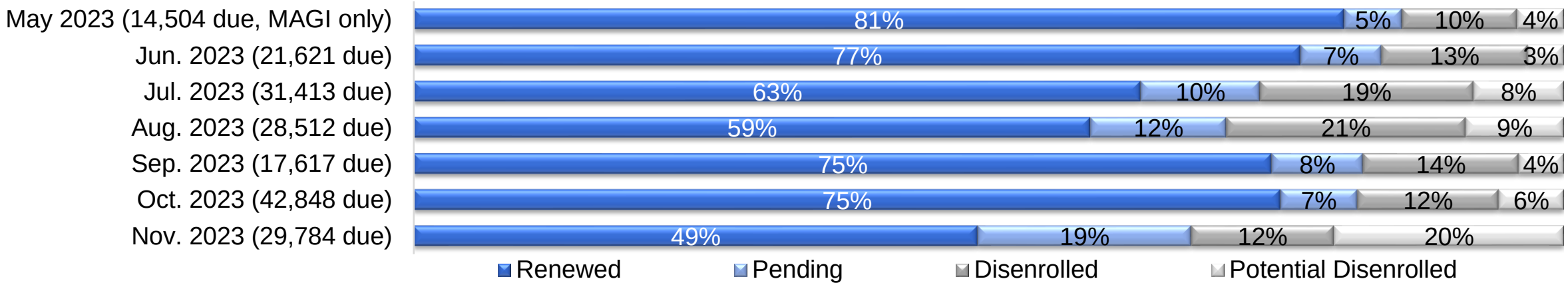
- **Dashboard** at https://dhcf.dc.gov/eligibilitydashboard is updated by the middle of each month (version to be released this week reflects data as of 12/18/2023).
- An accompanying **report on redeterminations** is available by the end of each month at https://dhcf.dc.gov/medicaid-renewal. Reports summarize information from the dashboard, but also provide additional detail on: characteristics of beneficiaries whose coverage was renewed; those who have not responded; and pending renewal timing.
- Data on specific topics may also be provided in meeting materials that accompany **biweekly community meetings**.





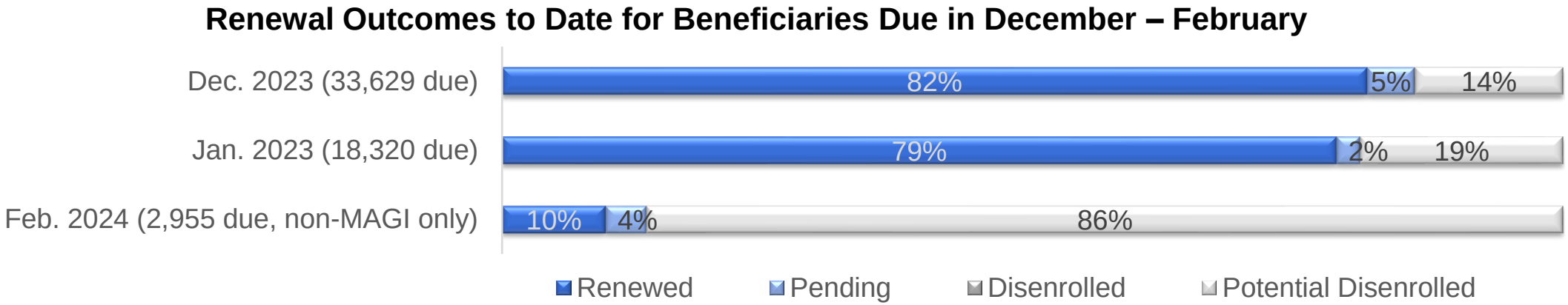
More Than Three-Quarters of Medicaid Beneficiaries Due Are Re-Enrolled or Have a Renewal Pending

Renewal Outcomes to Date for Beneficiaries Due in May – November



- For May through November overall, more than three-quarters of beneficiaries due for a renewal are re-enrolled or pending.
- Lower July, August, and November rates are due in part to a large number of "PHE beneficiaries" who were kept enrolled during the public health emergency but had income or other changes that made them appear ineligible and therefore unlikely to renew passively (i.e., no response required). October includes PHE beneficiaries but also many Supplemental Security Income (SSI) beneficiaries who are automatically extended based their receipt of SSI. September includes very few PHE beneficiaries.
- For May through November, the "Potential Disenrolled" category includes more than 12,000 non-disabled (i.e., MAGI) children under age 21 whose coverage terminations are paused or under review for reinstatement while DHCF ensures compliance with federal "ex parte" rules for passive renewals. For November, it also includes approximately 3,000 people with disabilities and those age 65+ (i.e., non-MAGI) who received one-month extensions through December to allow additional response time (earlier non-MAGI extensions have expired). For more information, see DHCF's Medicaid renewal meeting materials here.
- Renewal figures for all months will increase as responses are received during the 90-day grace period. The grace period ended in August for beneficiaries due in May, in September for those due in June, and so on. Beyond the grace period, individuals must submit a full application to reactivate their overage.

Medicaid Beneficiaries Due in December or Later Who Have Not Yet Responded Will Remain Enrolled Until They Reach Their Recertification Date

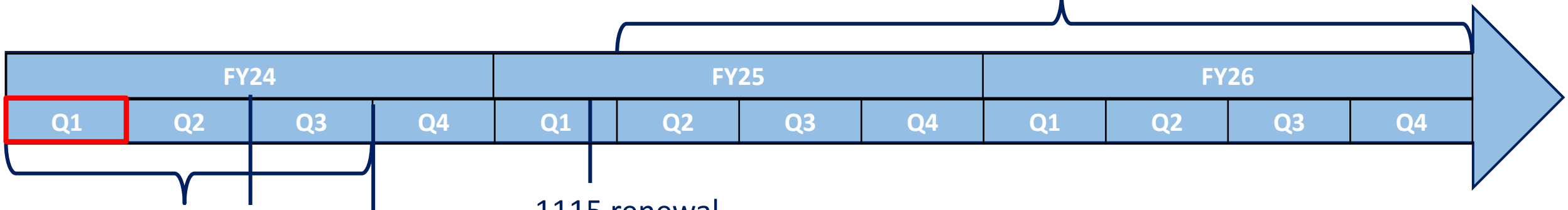


- Near or above 80% of beneficiaries due in December and January are renewed or pending. This is largely driven by a high passive renewal rate among non-disabled children and adults under age 65 (i.e., MAGI) for these months.
- February is incomplete because only beneficiaries with disabilities and those age 65+ (i.e., non-MAGI) have received renewal notices to date. Non-disabled children and adults under age 65 due in February will receive renewal notices by January 1.
- As noted earlier, DHCF is pausing terminations for non-disabled (i.e., MAGI) children under age 21 to ensure compliance with federal "ex parte" rules governing passive renewals, including 1,400 due in December. They will remain in the "Potential Disenrolled" category past their recertification date during the pause. For December, this category also includes approximately 1,000 people with disabilities and those age 65+ (i.e., non-MAGI) who will receive one-month extensions through January if they have not responded by their due date. For more information, see DHCF's Medicaid renewal meeting materials here.
- Renewal figures for all months will increase as responses are received during the 90-day grace period.

1115 Waiver Renewal Update

1115 Waiver Renewal Timeline

Infrastructure development and potential service on-ramp



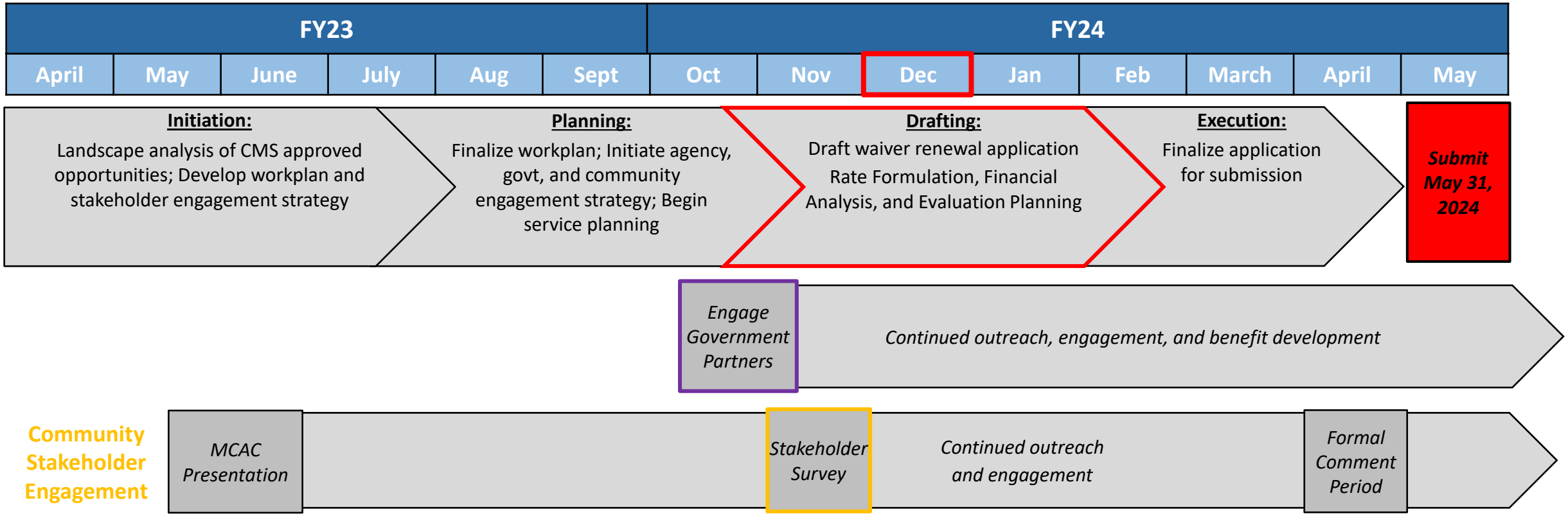
1115 renewal application development

1115 renewal approval

April 1, 2024: Target date to publish draft application for 30-day public comment period

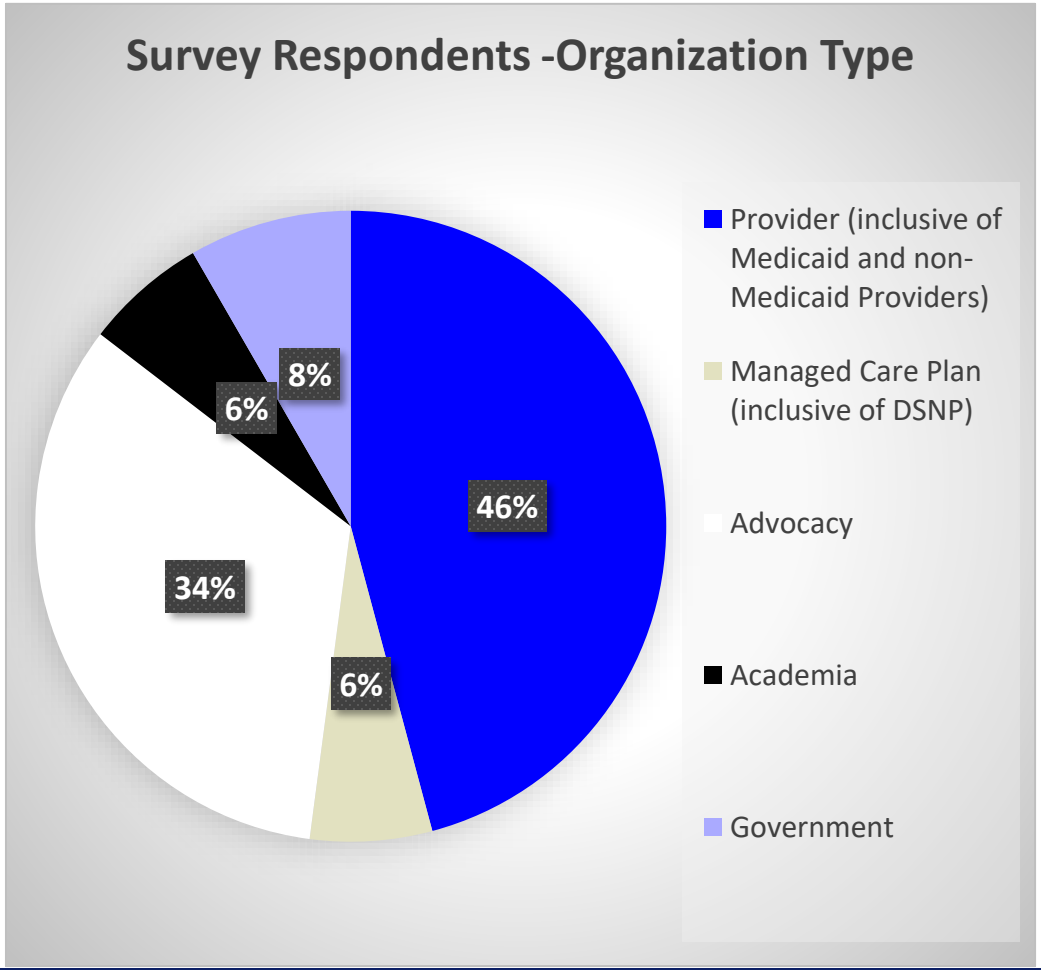
By July 1, 2024: 1115 renewal application submission (target 5/31)

1115 Waiver Renewal Workplan Overview



Stakeholder Feedback Survey – Response Overview

- Survey open from 11/3 to 11/27, and **48 responses** through the online form and email
  - High response rate compared to previous HCRIA-released RFIs/surveys
  - Most respondents have indicated openness to DHCF following up on their responses to discuss the waiver, as needed

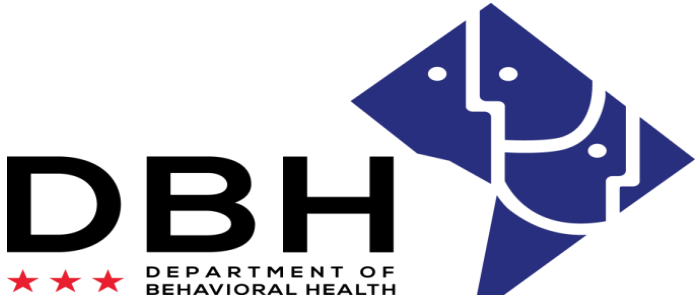


Next Steps and Upcoming Milestones

- Finalize survey response summary for DHCF leadership review
- January 12, 2024: Finalize waiver renewal application outline
- February 16, 2024: Finalize waiver renewal application draft for DC government staff review and approval
- March 29, 2024: DC Register notice of public comment period for published draft application

DC Stabilization Center

Advancing towards Systems Redesign



DC Medical Care Advisory Committee

December 20, 2023

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DC Stabilization Center Launch:
October 30, 2023

Addressing the Opioid Public Emergency

- The District of Columbia Stabilization Center (DCSC) exemplifies Mayor Bowser's priority and commitment to provide District residents with the opportunity to receive the right care, from the right provider, at the right time to address their Substance Use needs.
- The Department of Behavioral Health (DBH) developed the DCSC in partnership with Community Bridges, Inc. , as a new, critical enhancement to our existing Substance Use Continuum of Care.
- Community Bridges, Inc. operates the facility under the close monitoring and oversight of the Department of Behavioral Health.

District of Columbia Stabilization Center (DCSC)

35 K Street NE, Washington, DC 20002

Direct Access Line: (202) 839-3500

https://dcstabilizationcenter.com/

Key Features

- Voluntary, free of charge to all adults (18 and over) who meet medical eligibility criteria
- 24/7/365 medical / crisis and sobering services
- Low-barrier, compassionate, person-centered stabilization and crisis services
- 16 - 23 hr Observation beds; & 6 - Extended stay beds (up to 3 days) for observation and treatment of complex cases
- Individuals can be referred by provider, FEMS, family / friend or walk in
- Addresses Social Determinants of Health

Demographics

- Males – 76%; Females – 24%
- African American – 69%;
- All Others – 31%
- Age:
  - 30-39: 21%
  - 40-69: 59%
- Alcohol Intoxication – 61%;
- Opioids / OD – 9%
- All Others / Poly-Drugs – 37%
- Most impacted wards: 5, 7, and 8

DCSC Services

- Peer Counseling and Recovery Coaching appropriate to consumer's needs and readiness to change
- Harm Reduction services and supports
- Care management and coordination post discharge
- Navigation, linkages and referrals to housing, transportation, social services, and other supports
- Provides alternative disposition to first responders for people under the influence of substances and persons presenting in crisis

DCSC Services, contd.

- Medical Screening and Clearance / Stabilization / Support Services
- Addressing Consumers' immediate personal care needs
- Comprehensive diagnostic assessment for mental health, substance use disorders, and co-occurring conditions
- Medication Assisted Treatment (MAT)
- Referrals to appropriate ASAM level of treatment and recovery.

Clinical Stats

- 469 – total admissions (through 12/17)
- 17 patients– redirected to higher level of medical care from DCSC
- 339 - FEMS transports (72%)
- 20 mins - Median Drop / Turn Around Time by FEMS
- 75 – transported by family or significant others (16%)
- 20 hrs - Average LOS
- 32 – transferred to community care upon discharge
- 19 – discontinued treatment AMA
- Everyone leaves with Naloxone, treatment referral, and information regarding community resources & supports

Medicaid Managed Care Quality Strategy

MCAC Briefing

December 20, 2023

Overview of Quality Strategy Presentation

- Overview
- CMS Requirements
- Triple Aim
- Quality Framework – Goals and Objectives
- Monitoring Progress
- Questions

Medicaid Managed Care Quality Strategy

States are required to develop and implement a managed care quality strategy to assess and improve the quality of health care and services furnished by Managed Care Plans (MCPs)

The Quality Strategy must include the following elements:

- State's goals and objectives for continuous quality improvement and quality measures that will be used to measure performance
- Interventions and performance improvement projects that will be implemented to improve access, quality, or timeliness of care for PHP enrollees including plans to reduce health disparities
- Arrangements for annual external independent reviews of the quality outcomes, timeliness of, and access to, the services covered under each PHP
- State's structural and operational standards, and the mechanisms by which the State will comply with certain federal requirements (e.g. network adequacy; transition of care, etc.)

CMS Requirements

Submit the initial Quality Strategy to CMS for review;

Submit regular reports on the implementation and effectiveness of the Quality Strategy, which may be met through the federally-required external quality review (EQR) process; and

Review and update the Quality Strategy at least every three years or upon a “significant change”.

Triple Aim

Better Quality Care – Whole-Person Care

Healthier Communities – Preventative and Primary Care

Lower Costs – Value Based Purchasing Models

Quality Framework - Goals and Objectives

Objectives	Goals
Better Care	Goal 1: Ensure Access to quality, whole-person care
Healthy People, Healthy Community	Goal 2: Improve Management of Chronic Conditions
	Goal 3: Improve Population Health
Pay for Value	Goal 4: Ensure high-value, appropriate care
Provider Satisfaction	Proposed Goal 5: Improve Clinician Experience

Monitoring MCP Progress on Goals and Objectives

- Quality Measure Reporting – MCOs are required to report on all HEDIS and DHCF developed measures.
- Development of baseline and targets – DHCF will review MCO performance on key measures to set targets for improvement.
- Quality Assessment and Performance Improvement Programs (QAPI) – MCO process for conducting performance improvement projects and addressing disparities in care.
- Value-Based Payments – MCO provider incentive programs and alternative payment models.

NEXT STEPS

Public Comment Period

- Post quality strategy for 30 days – December 2023

CMS Review

- Submit to CMS – January 2024

Implementation

- Annual review – beginning January 2025

Thoughts or Questions?

District Quality Strategy

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Maya Deane-Polyak | Maya.Deane-Polyak@dc.gov
Division of Quality and Health Outcomes
Health Care Delivery Management Administration
Department of Health Care Finance

Medicaid Business Transformation DC: Technical Assistance Recommendations Report

Elizabeth Garrison
Health Care Reform and Innovation Administration, DHCF
Medical Care Advisory Committee
December 2023

AGENDA

I. **Program Context**

II. **Report and Key Findings**

- Market Landscape
- Stakeholder Assessment
- Performance Period TA Pilot

III. **Policy Recommendations**

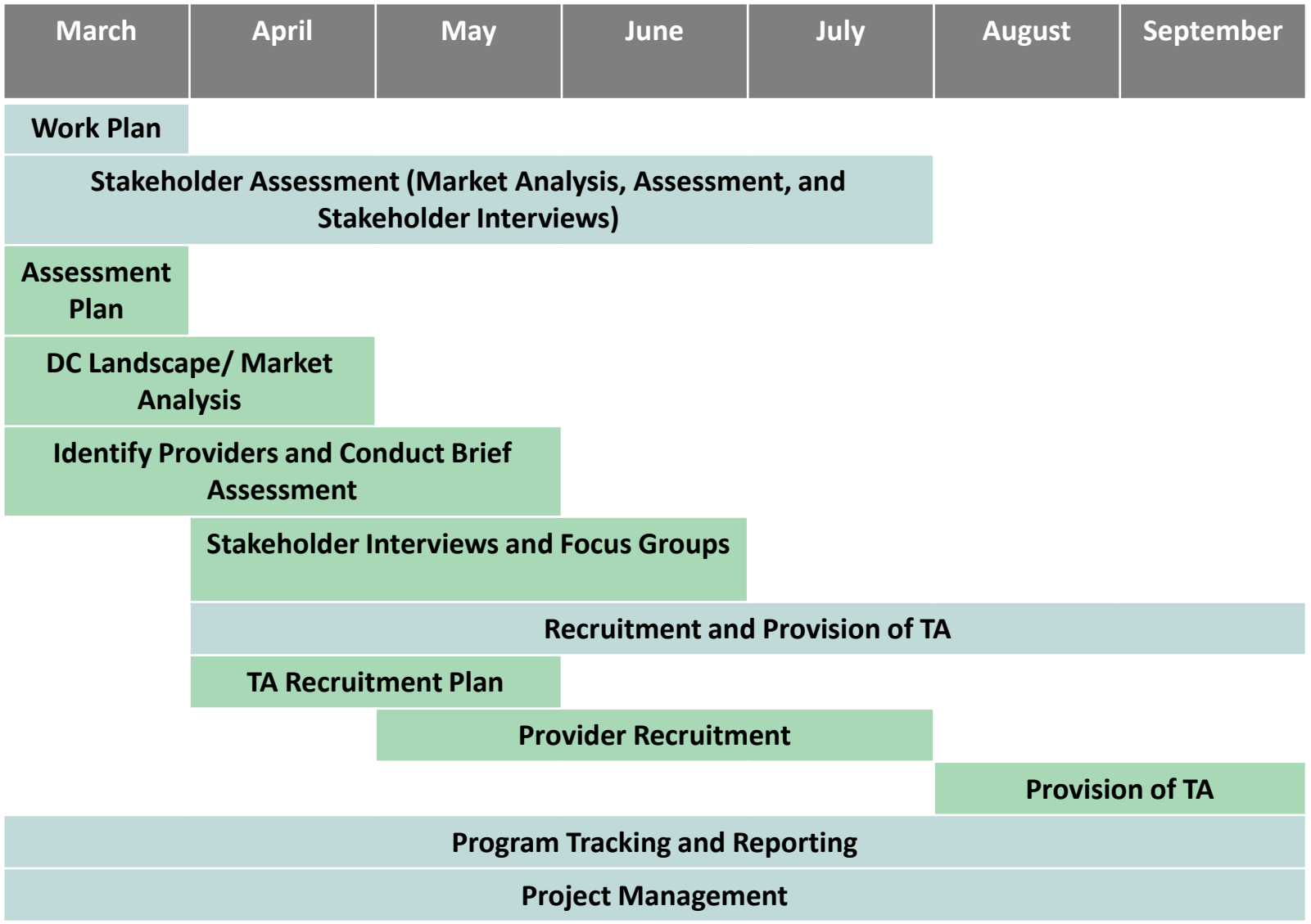
- Future TA Recommendations

Medicaid Business Transformation DC

Medicaid Business Transformation DC offers DC Medicaid providers tools and resources to deliver value-based care and to succeed in value-based payment arrangements to improve whole-person care and outcomes. Funded by the DC Department of Health Care Finance (DHCF), the initiative offers free technical assistance in the form of legal, clinical, financial, and business development support to help organizations align payment with the delivery of more accessible, equitable, coordinated, and accountable person-centered care.

Medicaid Business Transformation DC
Prepping for Value

PROGRAM CONTEXT



Medicaid Business Transformation Goals:

- Provide a brief, stakeholder assessment of Medicaid providers needs for legal analysis, financial consulting, and business development support.
- Design and deliver appropriate resources to meet these needs.

Together, these activities support Medicaid provider practice transformation and facilitate integrated whole-person care by enhancing providers' ability to collaborate across entities and participate in value-based care arrangements.

RECOMMENDATIONS FOR TECHNICAL ASSISTANCE REPORT CONTENTS:

Findings from a literature review of national value-based payment (VBP) best practices, published materials, and a scan of the District's healthcare reform landscape;

Results from focus groups, interviews, and a technical assistance (TA) survey with District organizations, agencies, and stakeholders on provider barriers and readiness to deliver value-based care; and

Policies and best practices for the District and DHCF that are drawn from leading edge states to advance value-based care and transform the healthcare delivery system.

Medicaid Business Transformation DC
Prepping for Value

SUMMARY OF KEY FINDINGS FROM THE BTTA REPORT:

1. District healthcare organizations/providers have specific technical assistance (TA) needs, and providers exhibit significant variation in their understanding of and readiness for a transition from fee-for-service to value-based payment (VBP) models.
2. Nationally, successful states advance VBP by building on the Health Care Learning and Action Network (HCP-LAN) framework to develop additional guidance for managed care organizations, with criteria, benchmarks, and standards that include both medical and behavioral health expenditures. These states also provide free TA, upfront investments, and resources to prepare healthcare organizations to deliver high-quality value-based care.
3. The transition to VBP for states across the country can take multiple years and significant technical support to prepare healthcare organizations to transform business, legal, and financial operations. This work includes supporting provider readiness for success with advanced payment models (APMs), facilitate provider collaboration and integration through individual and system-level transformation (e.g., mergers, acquisitions, and formation of provider-level entities). Examples include accountable care organizations, clinically integrated networks, and provider-led entities (PLEs).

STAKEHOLDER & MARKET ASSESSMENT METHODS

Medicaid Business Transformation DC
Prepping for Value

Brief Stakeholder Assessment:

A 30-minute survey was sent to more than 200 healthcare organizations with 26 organizations (13%) responding.

Brief Stakeholder Assessment Respondents

26 organizations responded to the brief assessment survey.

Nine organizations represent Wards 7 and 8

Organization Types	
Behavioral Health	12
Primary Care	2
Home Health	4
Nursing Home	2
Hospital	1
Other	5*

Other Includes: Homeless Services; Primary Care and Addiction Medicine; SUD; BH and Primary Care and Housing; Permanent Supportive Housing

Organization Size*	
< 100	2
< 200	4
< 300	6
<500	3
+1000+	11

Organization size is defined as number of unduplicated patients served on an annual basis.

Market Assessment:

A review of District and national VBP published reports and literature to inform findings and recommendations.

10 Focus Groups:

Six sessions for specific provider types (Behavioral Health, Home Health, Residential Treatment Providers) and four sessions with a mixed group of providers.

12 Stakeholder interviews:

Key informants representing providers, MCOs, District agencies, and provider associations.

Legal Analysis for the Establishment of a CIN, IPA or ACO in the District:

Adam Falcone, JD, Feldesman Tucker Leifer Fidell

Researched regulatory gaps or barriers for establishing provider networks.

KEY FINDINGS & TECHNICAL ASSISTANCE PILOT

KEY FINDINGS: MARKET LANDSCAPE

Domain	District Reported Barriers
Business/ Operational	▪ Lack of knowledge about VBP (e.g., contracts, negotiation) ▪ Untimely MCO payment ▪ Silos within District (e.g., lack of natural incentives to work together) ▪ Resistance to change/culture shift (particularly in independent practices) ▪ Staffing (e.g., limited resources, workforce shortages) ▪ Technology ▪ Corporate/government distrust
Financial	▪ Variation in rates ▪ Lack of standardization in payment methodology ▪ Cash management
Legal	▪ Lack of understanding with contracts and negotiating better arrangements ▪ Concerns with workforce and managing DC requirements
Clinical	▪ Improved access to care ▪ Standardized workflows ▪ Sufficient staffing
Data	▪ Lack of actionable, user-friendly information ▪ Better data needed on claims/payments; current systems inadequately setup ▪ Limited data systems

National VBP Models

What is successful?

- Successful Models
  - Adopt consistent standards, clear benchmarks
  - Focus on population health and embed health equity and outcomes
  - Include a framework that is not based on a FFS chassis
  - Alignment of metrics across payers
- Providers and Payers
  - Enhance infrastructure and upfront investments to build APM competencies
  - Develop robust IT investments and model
  - Develop transparent payer-provider partnerships

Why is it successful?

- Develop consistent VBP programs including metrics and performance targets across payers to send an aligned definition of high-value care
- Encourage providers to address community health needs and provide targeted interventions that address social drivers of health
- Allow upfront investments to develop infrastructure and necessary resources for effective participation in VBP
- Incent payer/provider partnership opportunities that align goals, data and resources, and establishes shared accountability
- Identify outcome measures and their definitions at the District level

How can we be successful?

- Identify infrastructure investment needs and mechanisms for addressing them
- Develop processes for outcome measure indicator identification and definition
- Identify VBP strategies and provide technical support to operationalize clinical progression from FFS to more advanced payment models
- Provide technical support that assists providers with understanding contract requirements
- Provide training to enhance understanding of financial implications of contracts, reserves and other aspects

KEY FINDINGS: STAKEHOLDER ASSESSMENT

Medicaid Business Transformation DC
Prepping for Value

Business Operations

- VBP foundations
- Building relationships with MCOs
- Evaluating payment models
- Change management
- Staffing for success
- Coaching the workforce to meet District requirements
- Stakeholder engagement and provider partnerships
- Developing clinical advisory boards and governance models that advance VBP
- Maximizing incentive payments
- Development of continuous quality improvement (CQI) strategies
- Assessing readiness for participation in VBP

Financial

- Cash management
- Coding, claims and reimbursement
- Billing and authorizations
- Actuarial analysis
- Determining and tracking the cost of care
- Implement strategies to identify sufficient reserves for risk-bearing arrangements
- Implement processes for quality and TCOC/shared-savings payments made six to nine months after the measurement period ends
- Maintaining financial sustainability

Legal

- Understanding VBP contracts
- Negotiating arrangements
- Forming independent physician associations (IPAs), clinically integrated networks (CINs)
- Merger and acquisition support

Clinical

- Understanding population health
- Measurement-based care
- Adopting validated screenings for physical and behavioral health conditions and social determinants of health
- Standardized clinical workflows
- Evidence based care pathways and workflows
- Clinical practice guidelines
- Team based care
- Managing complex/high need individuals
- Developing meaningful outcome and process measures that target health disparities and improve health equity

Data

- EHR support
- Population health management tools
- Tools to drive decisions, track quality measures, and monitor outcomes
- Best practices for collecting data
- Data analytics
- Collaboration with MCOs to identify gaps and opportunities
- Development of data-sharing agreements
- Using CRISP DC and eHealth to support providers

TECHNICAL ASSISTANCE PILOT OBJECTIVES

- Prepare health care organizations to succeed in delivering value-based care to improve patient outcomes.

- Expand quality measurement to capture more data on outcomes to inform care delivery, payment incentives and population health.

- Make key operational and financial system changes for accountable care transformation.

- Align payments with value-based care goals to move towards models that encourage coordination and health promotion.

Medicaid Business Transformation DC
Prepping for Value

PERFORMANCE PERIOD TECHNICAL ASSISTANCE PILOT

Medicaid Business Transformation DC
Prepping for Value

Three TA Priorities Across Each Domain Identified through the Brief Assessment

	Clinical	Business	Legal	Financial
1	Developing clinical/operational workflows	Establishing systems to track utilization, quality and costs	Forming accountable care organizations (ACOs), direct contracting, clinically integrated networks (CINs), independent practice associations (IPAs)	Developing financial modeling for value-based care investments
2	Adopting reimbursement/billing for integrated models of care	Conducting continuous quality improvement, measurement, outcomes	Establishing contracts with providers	Adopting value based-revenue cycle management
3	Establishing key performance indicators to monitor the effectiveness of new care models	Training and support for staff to run data reports	Structuring agreements and contracts	Designing financial measures for population health using clinical and demographic factors

RECOMMENDATIONS TO SUPPORT VALUE BASED CARE

SUMMARY OF KEY POLICY RECOMMENDATIONS

- **Provide 2-3 years of technical assistance and evaluation support** to providers to implement APM and evaluate outcomes.
- **Provide "on ramps" and upfront investments**, incentives and guidance beyond total medical spend to advance progress providers from pay for performance models to advanced APMs.
- **Increase** stakeholder engagement and communication in the design, development and implementation of VBP models.
- **Develop clear definitions and a common methodology** for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid managed care.
- **Align and limit quality measures** and increase incentives across MCOs.
- **Enhance opportunities** for integrated and complex care models through reimbursement and delivery models (health homes, CCBHCs).
- **Adopt regulations and guidance** to advance provider led entities (e.g., ACOs, CINs, IPAs) in the District.
- **Issue regulatory guidance** related to the FQHCs ability to capitated reimbursement from the Medicaid MCOs as part of the wrap payment submission.

RECOMMENDATIONS FOR FUTURE TECHNICAL ASSISTANCE

To successfully participate in an advanced APM (LAN Categories 3 and 4), providers must have sufficient financial reserves, a prepared workforce that demonstrates consistent and reliable clinical performance, and a robust ability to effectively oversee their revenue cycle, legal contracts, reporting requirements, and the exchange of information.

Ongoing support

- Provide two to three years of focused education, technical assistance, resources, and tools for organizations to advance their readiness to succeed in APMs, aligned with the LAN Category Framework and key competencies.
- Establish a forum for engaging providers, MCOs, and key stakeholders in surfacing, addressing, and resolving challenges, implementation barriers, and opportunities to advance capacity to operate under VBP arrangements across the District.
- Use a variety of channels to address new developments in the District's VBP plan and frequently asked questions, such as listening sessions, town halls, provider meetings, emails, podcasts, newsletters, and web-based resources.

Key topics to cover

- Assessing legal, contracting, and financial operations, including use of term sheets, as well as understanding operational costs and ensuring sufficient financial reserves.
- Incorporating and monitoring key performance indicators (KPIs) and metrics used in VBP contracts.
- Implementing care models and evidence-based guidelines that improve clinical outcomes.
- Using a health equity lens to analyze data and identify gaps in population health outcomes.
- Developing governance models to create and operate clinically integrated networks (CIN, IPA, ACO) in the District.
- Developing accountable partnerships that achieve clinical outcomes and cost savings.
- Evaluating organizations that lack alignment in terms of value and quality, and implementing strategies for improving, monitoring, and tracking metrics of significance to external stakeholders.

POLICY RECOMMENDATIONS

	Key Findings from Exemplar State	District Policy Recommendations
Design/ Implementation	▪ Readiness assessments are important in understanding the type of arrangement that providers can best operate with managed care organizations (MCOs). ▪ Clarity of roles is crucial to determining which party is responsible for administration versus healthcare delivery (e.g., MCO or provider). ▪ Stakeholder engagement is critical. Important to also include healthcare advocates to reduce concerns regarding access and equity. ▪ Harder for states to build APMs without any upfront provider level investments or technical assistance.	▪ Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid managed care in the District. (RI, MA, NC, IL, TN) ▪ Identify measurable goals (milestones) for the MCOs that participate with DHCF to achieve its strategic plan goals. (RI, MA, OH) ▪ Assign accountability for reaching the goal in the described timeline with financial implications for performance. (NY, OR) ▪ Develop attribution assignment and reassignment policies to assure members are appropriately assigned to their treating clinician. (IL) ▪ Develop processes that ensure timely and accurate exchange of information between payers and providers. (IL, TN)

POLICY RECOMMENDATIONS

	Key Findings from Exemplar State	District Policy Recommendations
Advancing to more APMs	▪ Important to develop model "on ramps" to advance progress providers from pay for reporting and pay for performance models to advanced APMs ▪ More advanced total cost of care (TCOC) models have the greatest potential for rewards but are still new and slower to progress given their complexity. ▪ The more advanced models, like those in New York, Pennsylvania, and Massachusetts, received federal funding/investments. ▪ Many advanced capitated models revert back to FFS. (CA) ▪ Very few aligned all-payer models (MD, VT). ▪ Mandatory models vary state-to-state and while they may be more impactful, may face opposition or force participation prior to readiness. (Only Maryland, New York, and Pennsylvania have some level of participation requirements for MCOs.) ▪ States and CMS are beginning to invest in payer alignment to reduce provider burden and increase impact of models (TN, OH) ▪ State and federal restrictions may challenge movement toward higher levels of accountability.	▪ Make upfront investments to: ○ Ensure that the financial incentives for achieving success under an APM yield a positive return on investment (RI, VT,PA, MA) ○ Incentivize providers who enter value-based payment arrangements with an MCO (RI, VT) ▪ Adopt regulations to Advance Provider Led Entities: ○ Encourage the creation of CINs, ACOs, IPAs through regulations and regulations. (RI, VT) ▪ Enhance the My Health GPS initiative (health home), as a valuable tool for providers to succeed in LAN 3 or 4 APM for complex populations (VT, RI)

POLICY RECOMMENDATIONS

	Key Findings from Exemplar State	District Policy Recommendations
Evaluation & Quality	▪ Current evidence is limited. ▪ State initiatives often implemented alongside other initiatives which impact evaluation. ▪ Vermont, Pennsylvania, and Maryland had federal funding for formal evaluations while other states had limited funds available for formal evaluations. ▪ COVID-19 skewed many findings for states that started VBP models before 2020. (VT)	▪ Quality: To transition providers from LAN Category 2 to LAN category 3: ○ Focus on reducing potentially avoidable emergency department visits, hospitalizations, and rehospitalizations (RI, MA, PA) ○ Align and limit quality measures and incentive across MCOs. (RI, MA, PA)

Subcommitees

Access Subcommittee

Strategic Session Planning

Including Subcommittee Discussion

Public Comment

Next Meeting

New Member Orientation – January TBD

MCAC – February 28th 5:30-7:30pm

APPENDIX

PERFORMANCE PERIOD TECHNICAL ASSISTANCE PILOT

Cohort	Live Webinars	Short-Takes & Tools
VBP Foundations	• VBP 101 (the "basics") • Data-Driven Insights to Advance Behavioral Health Quality • Allocation of Value-based Payment Incentive Payments to Optimize Performance • Clinical and Programmatic Implications of VBP • VBP 101- Teaching to the Tools	• Risk Mitigation and Risk Reserves • How to Negotiate Your Share with Payers • What's Your Value Proposition? • Mergers & Acquisition • ACO Foundations
Behavioral Health	• Promise and Perils of VBP • Measurement Based Care for VBP • Getting to an Advanced APM as a BH Provider • Managing Complex Populations	• VBP Terminology 101 • Attribution • VBP Levels • Risk Adjustment • Primary Care Integration • VBP Readiness Tool
FQHCs	• Clinically Integrated Networks: Build, Buy or Stay on the Sidelines • Value-based Payment: Is it disrupting health care for the better? • Role of a Capitated Alternative Payment Model • Value-based Payment: Is it disrupting health care for the better? Role of a Clinically Integrated Network	• Term Sheet for Contracting
Legal and Contracting	• Strategies for Negotiating Managed Care Contracts • Understanding Key Terms in Managed Care Contracts • Where Quality Meets Legal • Key Considerations for Value Based Payment Arrangements	• Managing Expectations Related to the BH Carve-In • Privacy Requirements and Care Coordination: Leveraging the functionality of CRISP to Build Your Clinic's VBP Capacity • Understanding Your Clinic's Current Strengths and Potential In the Context of D.C.'s Medicaid MCOs' Legal Obligations to DHCF • Evaluating D.C.'s Medicaid Provider Ecosystem for Partnership Opportunities to Strengthen Your Clinic's Negotiating Position • RAG Status Tool For VBP • RAG tool for quality measures and contracts • Resources for gaining a better understanding of how your organization fits into the District's goals and priorities for Medicaid Managed Care • Health Care Provider Checklist for Entering into Managed Care Contracts

PERFORMANCE PERIOD TECHNICAL ASSISTANCE PILOT

VBP Toolkit Resource

VBP Toolkit Elements
Achieving Total Cost of Care
Building a Positive Payer-Provider Partnership
Contracting for Value Based Payment
Creating a VBP Presentation for Payers
Developing Your Value Based Payment Value Proposition
Forming Strategic Partnership Agreements and Care Compacts
Promoting Value Based Purchasing to the Behavioral Health Workforce
Quality Measurement for Behavioral Health Providers
Succeeding in Advanced Alternative Payment Models
Technology Infrastructure to Support VBP
Understanding Your Population
VBP Milestone Grid
VBP Readiness Assessment
VBP Terms and Definitions

Virtual VBP Learning Collaborative

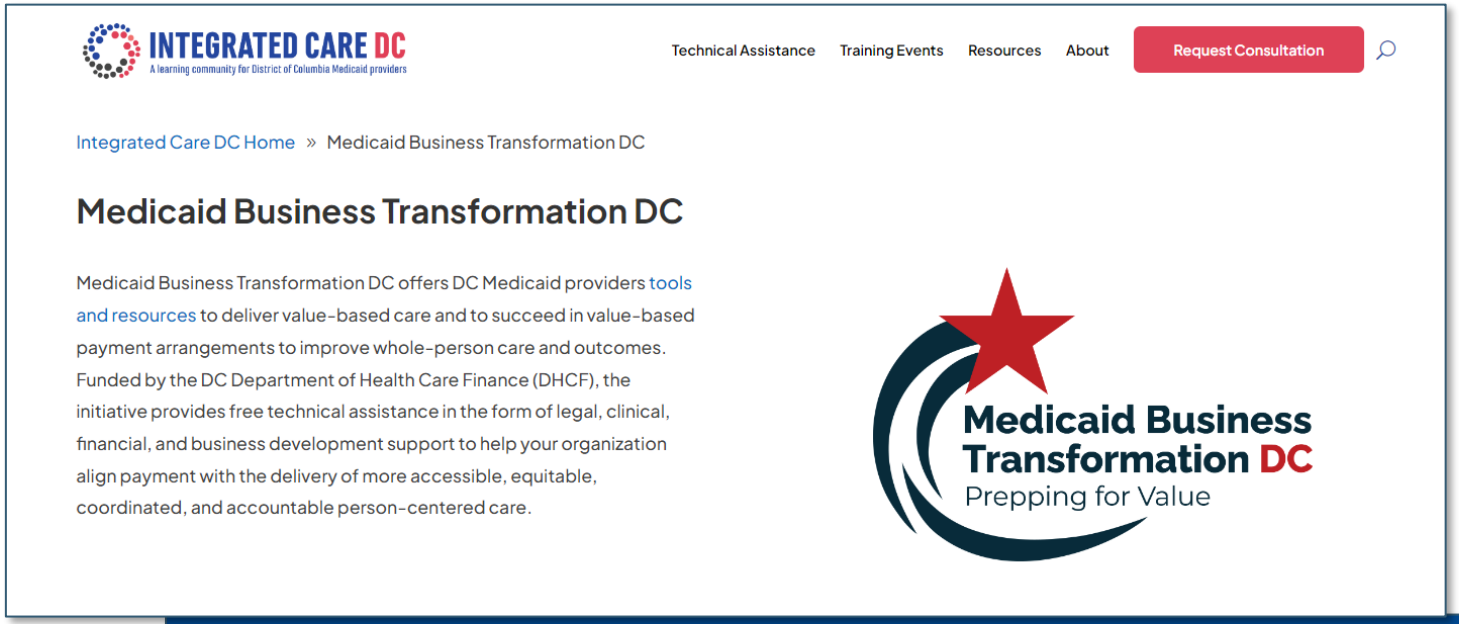
Legal Track	Financial Track
Forming Community Partnerships to Participate in VBP Arrangements - Part 1	Revenue Cycle Operational Excellence: A Foundation for Value-Based Payments
	Evaluating Payment Models and Financial Modeling
Forming Community Partnerships to Participate in VBP Arrangements - Part 2	Clinical Documentation and CDPS+Rx Coding Guidelines for Value-Based Payment Optimization

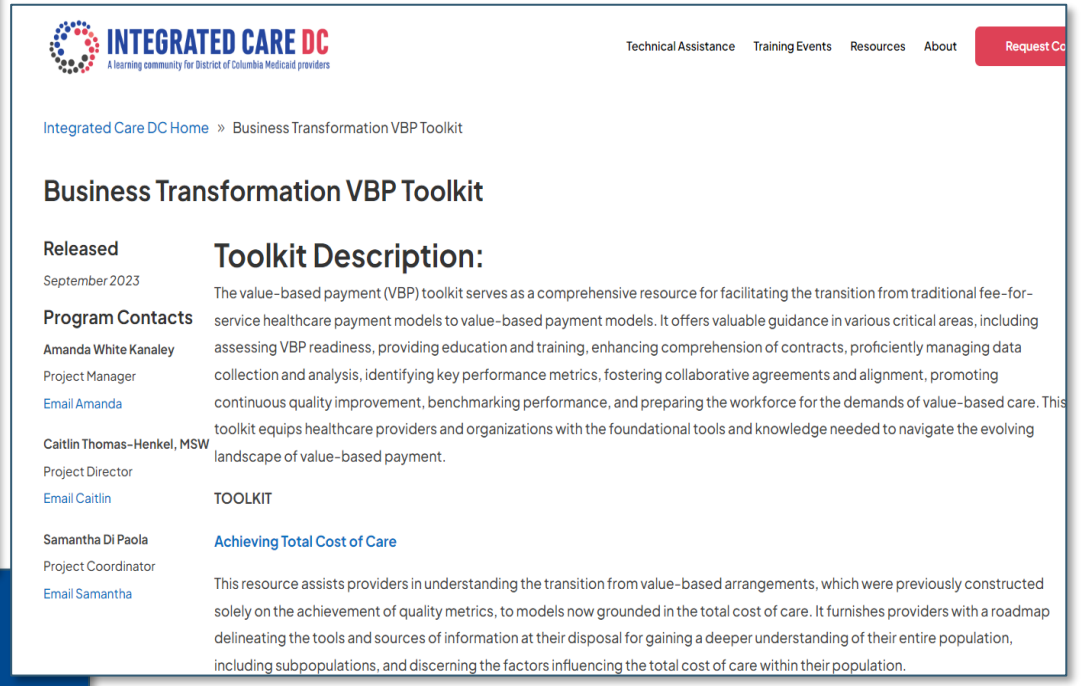
+ An FQHC-specific VBP workshop

All recordings and materials are posted on the Integrated Care DC – Business Transformation webpage:
www.integratedcaredc.com/medicaid-business-transformation-dc/

BUSINESS TRANSFORMATION RESOURCE WEBSITE

www.integratedcaredc.com/medicaid-business-transformation-dc/





BUSINESS TRANSFORMATION GRANT PROJECT LEADS

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Prepping for Value

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Medicaid Business Transformation DC
Prepping for Value

RECOMMENDATIONS FOR NEXT STEPS

1. Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid-managed care in the District
2. Identify measurable goals (milestones) for the MCOs that participate with DHCF to achieve its strategic plan goals
3. Assign accountability for reaching the goal in the described timeline with financial implications for performance
4. Develop attribution assignment and reassignment policies to assure members are appropriately assigned to their treating clinician
5. Make upfront population health investments available to providers who agree to value-based payment arrangements with an MCO
6. Align quality measures and incentive across MCOs
7. Limit quality metrics to a manageable number of measures across payers so providers can focus their quality improvement work
8. To transition providers from LAN Category 2 to LAN Category 3, focus on reducing potentially avoidable emergency department visits, hospitalizations, and rehospitalizations
9. Develop processes that ensure timely and accurate exchange of information between payers and providers
10. Ensure that the financial incentives for achieving success under an APM yield a positive return on investment
11. Encourage the creation of CINs, ACOs, and IPAs
12. Consider leveraging the previous My Health GPS initiative as a valuable tool for providers to succeed in LAN 3 or 4 APM